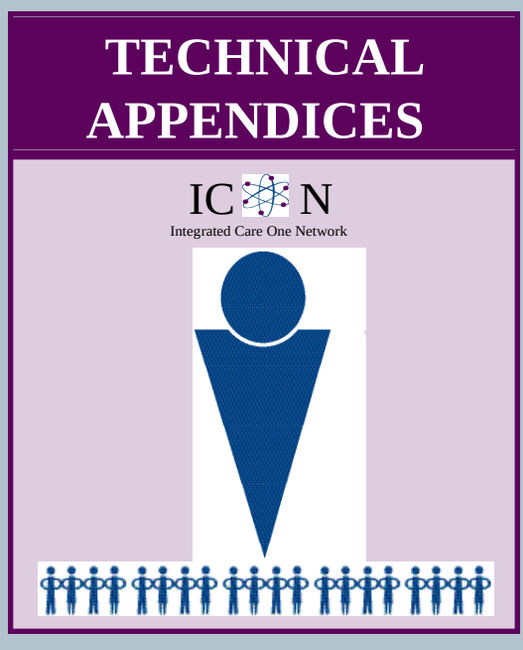
Integrated primary, community and continuing care: technical appendices / Midland Health Board

Integrated Primary, Community & Continuing Care
Bunchúram, Cúram Pobal agus Cúram Leanúnach Iomlán

An Bord Sláinte Lár Tíre
Midland Health Board

Midland Health Board

TECHNICAL APPENDICES



e: integratedcare@mhb.ie w: www.mhb.ie

Secta
PARTNERS FOR CHANGE

ICN
Integrated Care One Network

An Bord Sláinte Lár Tíre
Midland Health Board

TECHNICAL APPENDICES

Report June 2003

APPENDIX A - PARTICIPANTS

PROJECT GROUP

Name	Title
Veronica Larkin	Project Manager
Martina Martin	Project Support
Orla McEvoy	Project Support
Grainne Stafford	Secta Consultant
Peter Morgan	Secta Consultant
Helen Tucker	Secta Consultant

STEERING GROUP

Name	Title
Breda Crehan Roche	Director of Disability Services - Regional
Margaret Feeney	Project Specialist Older Persons - Regional
Dr.Phil Jennings	Specialist in Public Health & Planning - Regional
John Kenny	Director of Information Systems - Regional
Dorrie Mangan	Acting General Manager - Longford / Westmeath CC
Pat Marron	Primary Care Unit Administrator - Regional
Liam O'Callaghan	General Manager - Laois / Offaly CC
Pat O'Dowd	Asst. Chief Executive Officer - Regional
Richard Walsh	General Manager Mental Health Services - Regional
Aiden Waterstone	Director of Child Care Services - Regional

CONSULTATIVE GROUP

Name	Title
Carmel Breaden	Acting Principal Psychologist - Longford / Westmeath
Dr. Catherine Browne	Acting Clinical Director - St. Fintan's Hospital, Portlaoise
Eleanor Dowling	Director of Public Health Nursing - Laois / Offaly
Dr. Ina Kelly	Senior Area Medical Officer - Longford / Westmeath
Paul McGuinness	Senior Environmental Health Officer - Longford
Donie Murtagh	Community Services Manager - Longford / Westmeath CC
Mick O'Hehir	Asst. Director of Nursing - Tullamore
Marie Prendergast	Occupational Therapy Manager - Longford / Westmeath
Majella Robinson	Clinical Audit Officer - Regional
Trudie Rohan	Acting Director of Nursing - Ofalia House, Tullamore

APPENDIX A - PARTICIPANTS

EXTERNAL INTERVIEWS

Name	Department
John Brady	DOHC
Paddy Burke	GMS
Declan Byrne	Laois County Development Board
Denis Doherty	HeBE/OHM
Jimmy Duggan	DOHC
Ms Frances Fletcher	DOHC
Fergal Goodman	DOHC
Jack Keyes	Offaly County Development Board
Ros Moran	Health Research Board
Richard Nolan	DOHC
John Owens	Mental Health Commission
Frank Sheridan	Longford County Development Board
Michael Smith	DOHC
Maurice Stenson	Westmeath County Development Board
Mary Van Lieshout	National Disability Authority
Dr Dermot Walsh	DOHC

APPENDIX B - QUESTIONNAIRE FORMAT

MIDLAND HEALTH BOARD
MODELS OF INTEGRATED PRIMARY AND COMMUNITY CARE

"Person-centred services delivered in a non-acute setting in a continuous way."

QUESTIONNAIRE PRIOR TO INTERVIEW

Please contact the following if you have any queries:

Veronica Larkin, Project Manager. E-Mail Address: Veronica.Larkin@mhb.ie
Martina Martin, ICT Patient/Client Support E-Mail Address: Martina.Martin@mhb.ie

A. INTERVIEWEE DETAILS

Please give your name, job title, base of work, contact telephone number and email address.

B. SERVICE RESPONSIBILITY

Please provide a brief description of the service that you provide or are responsible for – the service provided by location & care group, staff employed, budget and activity data in broad terms. Please provide a broad outline of the size and scope of the service. Further detail is not required at this stage.

C. CURRENT SERVICE

Please describe how your service currently operates, and current ways of working with particular reference to teams and partnerships. Please describe any services that you provide in collaboration with, or within the following sectors – primary, community, acute, voluntary, private. Please describe links with other providers and cross referral systems.

D. TEAMWORKING

Please provide examples of any teams or service links that span the following: inter-professional, multi-disciplinary, multi-agency, academic and any other.

E. GOOD PRACTICE

Please provide up to 3 examples of each of good practice and planned service developments.

F. INTEGRATED CARE

What does integrated care mean to you?

G. MODELS AND FEATURES

Could you describe any models of good practice in your own discipline or elsewhere.

H. KEY FEATURES

Could you describe key features of integrated primary and community care (using the above models or others as a guide)

APPENDIX C - SWOT ANALYSIS

Report June 2003

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

INTRODUCTION

Staff completing the questionnaire were asked the following question.

"How integrated is your service? Please provide up to 3 examples of where the service has strengths, weaknesses, opportunities and threats/challenges with regard to the level of integration."

The responses from the 63 questionnaires have been analysed by theme. The questionnaire responses were analysed by client group: primary care, mental health, older people, children and disabilities. A generic category was also created for the many staff who work across client groups.

SUMMARY RESULTS

Rank	Strengths	Weaknesses	Opportunities	Threats
1	Staff attitudes	Infrastructure	Appropriate Care	Staff attitudes
2	Client centered	Communication and Information	Comprehensive	Financial
3	Staff skills	Geography and Facilities	Knowledge	Staffing numbers & training
4	Communication	Staff capacity	Networking	Infrastructure
5	Infrastructure	Staff attitudes	Staff training and development	Lack of a model

STRENGTHS

Summary Analysis

The top five themes for strengths have been analysed and are listed in the table below.

The strengths of integration currently were viewed as staffs positive attitude, and the way that the service is client centred. A very positive approach to integration was expressed throughout the questionnaires, and therefore there is a willingness and commitment to working in this way from many of the staff concerned. Staff skills were thought to be an asset in developing integration. Communication systems were considered to be an important dimension to integrated care, although many referred to informal means, based on good will rather than well-developed infrastructures. The fact that there have been a number of partnerships established for specific care groups, such as with the voluntary sector and the community was considered to be a strong basis on which to develop integrated care.

Theme	*Total*
Staff attitudes	59
Client centered	37
Staff skills	33
Communication	29
Infrastructure	28
Partnerships	26
Quality	11
Co-ordination	7
IT	6
Other	5

Table Summary of General Themes (Strengths)

APPENDIX C - SWOT ANALYSIS

Detailed Analysis by Care Group

A full breakdown of themes is provided in the table below, which describes in more detail the contributions made under the heading of strengths.

The major theme consistently mentioned was that of their own staff, the professional attitudes and the flexibility of them to accept new practices and methods of working. On the whole, those questioned were very positive regarding the ability of their service to incorporate further disciplines into their current skill base, especially those involved in primary care.

Many thought that their service was already very focused towards the client and their families, particularly for mental health services.

The infrastructure required to integrate primary and community care was referred to constantly, services believing they already worked within dependable structures and that theirs would be a valuable model of working.

Communication was also regularly referenced, although as the majority of those services who mentioned this were those in generic care. It is indicated that these links may be within their own services and not necessarily across other agencies.

Three particularly important points were made: focus on prevention; the transparency of the service and continuous assessment. These issues were also raised within the workshops as critical factors that stood out as possibly areas in which improvements must be made for integration to be successful.

Theme	Total	%
Professional Attitude	32	51%
Wide skill base	23	37%
Flexibility	17	27%
Multi-disciplinary approach	17	27%
Credible structures/Existing plans	16	25%
Client centered	15	24%
Communication	11	17%
Quality strategy	11	17%
Goals	10	16%
Respect	10	16%
Training	10	16%
Partnerships	9	14%
Better care for multiple need clients	8	13%
Good links with community	8	13%
Coordination	7	11%
IT compatible	6	10%
Easy access	6	10%
Management info available	6	10%
Transparency	4	6%
Prioritizing	3	5%
Continuous assessment	3	5%
Spread out across community	2	3%
Provides empowerment	2	3%
Focus on prevention	2	3%
Interaction with top management	1	2%
One to One clinics	1	2%
Irish Advocacy Network	1	2%

Table Themes from questionnaires (Strengths)

APPENDIX C - SWOT ANALYSIS

WEAKNESSES

Summary Analysis

The top five themes for weaknesses have been analysed and are listed in the table below.

The main weakness in trying to work in an integrated way is the lack of an infrastructure, according to the respondents of the questionnaire. This would include the structures, systems and processes that need to be designed to support and facilitate integrated working. The lack of communication and information on the services was considered to be another weakness. Staff referred to the large geographical spread that the MHB covers, and the fact that staff are typically not co-located due to inadequate facilities within their area. Staff capacity was also cited as a weakness, where there are high demands on staff time. Staff attitudes are considered to be a weakness and a strength. Clearly it is critical that staff have a willingness to work in an integrated way. In practice this is unlikely to be universal, and where staff are resistant or hesitant this will hold up the development of integrated care.

Theme	Total
Infrastructure	44
Communication and Information	32
Geography and Facilities	27
Staff capacity	23
Staff attitudes	23
IT	19
Perceptions - professional and public	10
Financial implications	9
Client priorities	9
Accountability	7

Table Summary of General Themes (Weaknesses)

Detailed Analysis by Care Group

A full breakdown of themes is provided in the table below, which describes in more detail the contributions made under the heading of weaknesses.

The greatest issue to arise was that of infrastructure, such as a lack of a co-ordinated approach to multi-disciplinary teamwork, poor assessment and review procedures and the lack of existing integration at the level of manager. A high proportion of respondents working in both services for people with mental health and services for older people pointed this out.

The next major concern was to do with communication and the balanced sharing of information and this was echoed for all services.

Geographical difficulties and the lack of adequate facilities were pointed out frequently, again by a variety of agencies.

Staff attitudes was raised as a concern, particularly for those working in child health. The questionnaires revealed more a

APPENDIX C - SWOT ANALYSIS

fear of a perceived attitude of other staff and agencies.

The limited access to IT was consistently referred to, backing up the issue of the present lack of infrastructure.

The financial implications of integrated care were not referred to by as many as anticipated, but was mentioned more so in the questionnaires relating to services for older people and mental health services. Accountability and essentially the fact that their service had no operational responsibility was a concern for some services.

There were several interesting points, which need to be drawn out, as they have been supported by feedback in other parts of the process. These are the lack of knowledge of other agencies and lack of support for carers and families. In particular one respondent pointed out that there presently existed 'no reward for excellence'.

Theme	Total	%
Geographical difficulties/ Inadequate Facilities	27	43%
Lack of information/communication links	24	38%
Increased work load/Staff shortages	23	37%
Limited access to IT	19	30%
No coordinated approach to MDT	16	25%
No current structure in place	15	24%
Inflexibility	12	19%
Perceptions	9	14%
Expense	9	14%
Staff attitudes	9	14%
Priorities for patient care	8	13%
No operational responsibility	7	11%
Lack of knowledge of other disciplines	6	10%
No complaints procedure	4	6%
Poor early assessment / review	4	6%
No integration at Manager level	3	5%
Institutionalization	2	3%
Lack of knowledge of other agencies	1	2%
Links with hospital	1	2%
Paternalism	1	2%
Tokenism	1	2%
No reward for excellence	1	2%
Lack of support for carers and families	1	2%

Table Themes from questionnaires (Weaknesses)

OPPORTUNITIES

The top five themes for opportunities have been analysed and are listed in the table below.

The opportunity to provide the client with appropriate care was considered to be the greatest opportunity in introducing a formal model of integrated care. The respondents spoke of developing services, which meet the needs of service users, and designed along with those who receive the service. The opportunity to develop a more comprehensive service by pooling resources was considered to be a desirable goal, particularly working across the statutory and non-statutory sector.

The opportunity to share knowledge, skills and expertise by sharing between staff and agencies was stressed, and opportunities for shared and joint staff training and development. The importance and benefit of networking generally was ranked as one of the top five opportunities.

APPENDIX C - SWOT ANALYSIS

Theme	Total
Appropriate Care	67
Comprehensive	40
Knowledge	31
Networking	25
Staff training and development	21
IT	16
Perception	12
Patient Focus	10
Quality	2
Leadership	2

Table Summary of General Themes (Opportunities)

Detailed Analysis by Care Group

A full breakdown of themes is provided in the table below, which describes in more detail the contributions made under the heading of opportunities.

These themes were factors considered to be major opportunities within the framework of integrated care.

The one area which stands out is that of providing appropriate care for the client, whether that was through easier access, an increased understanding of the care plan, or through improvements in the review and monitoring of services provided.

The possibility of a comprehensive service, or 'One-stop-shop' was also high on the agenda for the majority of agencies but particularly espoused by services for older people and for those with learning disabilities. Additionally, there was also the wish for a wider base of professions to be incorporated into the new system including new projects.

The opportunity to obtain detailed knowledge of how other teams work and the chance for further research and education was consistently referenced by all parties.

The importance of linking networks between the various disparate agencies, including the development of IT systems was another key point.

Essential training and the investment in staff was deemed a further opportunity to be taken.
The consideration of image improvement both within the health service and for the general public was a strong theme.

The empowerment of the client, the development of a quality initiative and the importance of leadership / trust were not frequently specifically referred to, but could be considered as integral to many of the responses.

APPENDIX C - SWOT ANALYSIS

Theme	Total	%
Improve links	25	40%
Knowledge of other teams work	25	40%
Comprehensive service	20	32%
More appropriate care	17	27%
IT development	16	25%
Shared training	15	24%
Efficiency	14	22%
Increase awareness of care plan	13	21%
Image improvement	12	19%
Review services more effectively	9	14%
Better monitoring	9	14%
New projects / services	7	11%
Investment in staff	6	10%
Research / Education to others	6	10%
Easier access	5	8%
Service at own home/community	5	8%
Focus on patient	5	8%
New health action plans	4	6%
Wider base of professions	4	6%
Empowerment	4	6%
Development of quality initiative	2	3%
Leadership / Trust	2	3%
Increasing elderly population	1	2%

Table Themes from questionnaires (Opportunities)

THREATS

Summary Analysis

The top five themes for threats have been analysed and are listed in the table below.

Staff attitude was considered to be the highest threat to furthering the model of integrated care. Pockets of resistance have been described, where staff are protecting their professional territory. Financial pressures are also considered to be a real threat to proceeding with the model, particularly if re-organisation of the service requires an initial investment. Respondents referred to the lack of staff and training, particularly within the context of the current recruitment freeze. The need for an appropriate structure to support integrated care was identified as a threat, and the lack of a formal model that was identifiable, explicit and signed up to was considered to be a threat to developing integrated working. Therefore the process of formalising integrated care may be considered to be strongly supported by respondents.

APPENDIX C - SWOT ANALYSIS

Theme	Total
Staff attitudes	48
Financial	37
Staffing - Numbers and Training	34
Infrastructure	26
Lack of a model	22
Increased demand / expectations	20
IT	15
External factors	10
Patient Confidentiality	1
Communication	1

Table Summary of General Themes (Threats)

Detailed Analysis by Care Group

A full breakdown of themes is provided in the table below, which describes in more detail the contributions made under the heading of threats.

The dominant theme was that of staff attitudes and the possible emergence of inter-professional rivalry. However within primary care services this scored very low, whilst scoring more highly in child care services.

Inadequate funding and the lack of budgetary information was another major concern across all respondents. This in turn was reflected by worries about staffing levels and the amount of training running an integrated care system would require. Industrial relations issues were also raised.

Both anxiety about pre-existing structures within the Midland Health Board being too resistant to change, and the lack of a focused model of care were recurrent although questionnaires from primary care services did not refer to this as such a key issue. However, primary care services did attach high importance to the problem of increased demand / expectations.

The current lack of IT was raised by all, and in particular by generic staff.

Several external factors were mentioned including geographical difficulties, the Social Inspectorate and the current socio-economic and political factors.

The issue of patient confidentiality was broached on one occasion. The limitations of the communication systems were only referred to.

One final point was the matter of morale and feeling under-valued. One respondent believed it necessary to introduce a system whereby high performing services and staff are fully recognised.

APPENDIX C - SWOT ANALYSIS

Theme	Total	%
Inadequate funding	36	57%
Attitudes	34	54%
Staff shortages	25	40%
Rigid structures in Board	20	32%
No focused model of care	16	25%
Lack of IT	15	24%
Interprofessional rivalry	13	21%
Increased Demands	8	13%
Public perceptions	8	13%
Lack of training	7	11%
Current socioeconomic and political factors	5	8%
Increased expectations	4	6%
Dissolution of current agreements	4	6%
Geographical difficulties	3	5%
No management info	3	5%
Reduced care for longstay patients	2	3%
Legislation	2	3%
Industrial relations issues	2	3%
Patient confidentiality	1	2%
Social Inspectorate	1	2%
No budgetary information	1	2%
Poor communication	1	2%
Low morale / feel under-valued	1	2%
Lack of quality evaluation	1	2%
Courts - legal action	1	2%

Table Themes from questionnaires (Threats)

CONCLUSION

The questionnaires have helped to identify the key strengths and opportunities within the MHB so that these can be capitalised on. The project of developing a model of integrated care has been designed so that it provides an opportunity to build on good practice. Therefore, the sharing of this level of information with staff has proved to be invaluable.

The identification of weaknesses and threats has in turn been highly valuable, and has helped to identify the challenges that will be facing the MHB. The staff have been open and honest about the limitation and restrictions within their services, and have made suggestions about how these can be addressed.

The material from the questionnaires has provided a very rich basis for further work. The themes from the SWOT will be reflected in the action planning.

The information from the questionnaires provides the MHB with a strong evidence base and a mandate to proceed with developing and implementing its new model for integrated care.

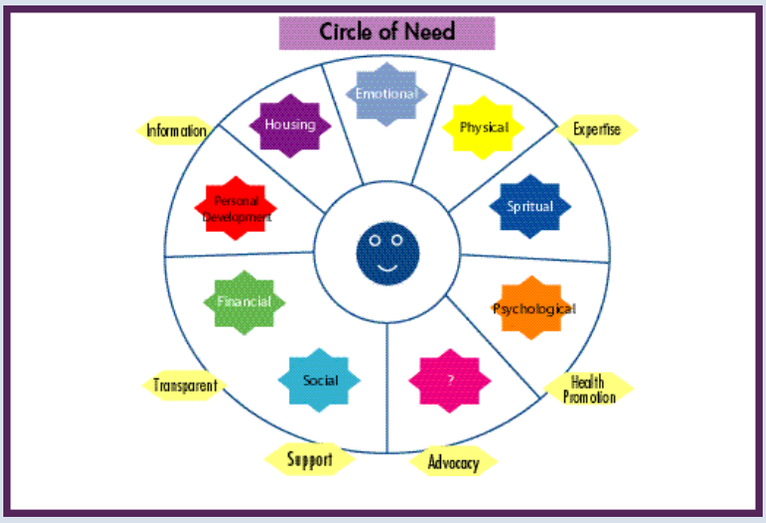
APPENDIX D - GOOD PRACTICE MODELS

18 presentations

Ref	Client Group	Topic	Name
1	Children	Children with Specific Language Impairment	Lily Lalor Senior Speech & Language Therapist
2	Mental Health	Integrated Occupational Therapy Service	Maria O'Connell Occupational Therapist
3	Mental Health	Waiting List Initiative- Pathways of Care and Stepped Care Model	Conor Owens Senior Psychologist
4	Mental Health	Integrated Mental Health Services in Tullamore Sector	Mick O'Hehir Acting Director of Nursing
5	Children	School Vaccination Programme	Dr Ina Kelly Senior A.M.O.
6	Older People	Rehabilitation & CRU	Eileen Leavy PHN.
7	Children	Children with Speech and Language Difficulties	Elizabeth Kelly Speech & Language Therapy Manager
8	Children	Developmentally Delayed Children	Betty Fox Public Health Nurse
9	Older People	Multi-agency support to carers	Marian Delaney Hynes Carer Co-Ordinator
10	Primary Care	Breastfeeding Support Clinic	Mary Healy Public Health Nurse
11	Primary Care	Early Identification, Prevention & Management of Postnatal Depression	Mary Curran Public Health Nurse
12	Primary Care	School Vision Screening to prevent Lazy Eye in Childhood	Dr Marie Houlihan Community Ophthalmic Physician
13	Disability	The Springfield Centre - Physical and Sensory Disabilities	Breege Donoghue Manager Springfield Centre
14	Mental Health	Primary Care entry point to Adult Mental Health	Lorcan Martin Consultant Psychiatrist
15	Older Persons	Rehabilitation in St Vincent's Hospital	Catherine O'Keeffe Director of Nursing
16	Children	Early intervention for support to children & families	Maura Morgan Occupational Therapy Manager
17	Primary Care	The Structured Diabetic Project	Corina Glennon / Slattery Manager Community Dietician Services
18	Primary Care	Ante-natal Classes	Mary Wallace Senior Physiotherapist

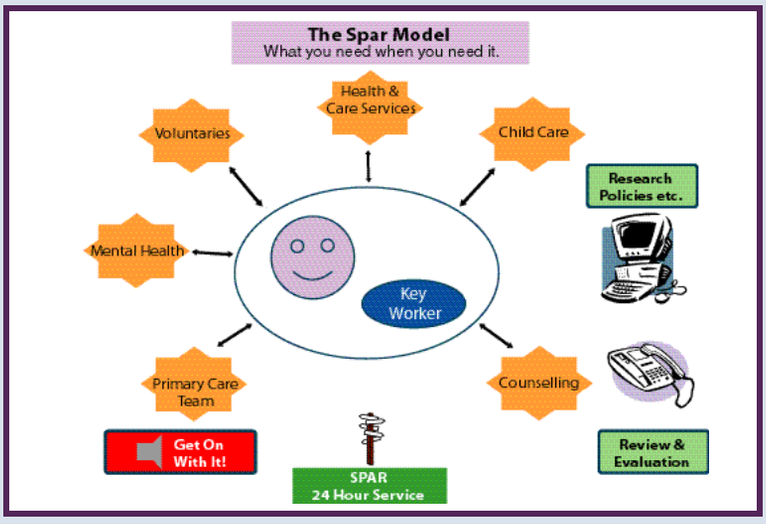
Table: Presentations Made at Workshops on Models of Good Practice in Integrated Care

APPENDIX E - MODELS OF INTEGRATED CARE DEVELOPED IN WOKSHOPS



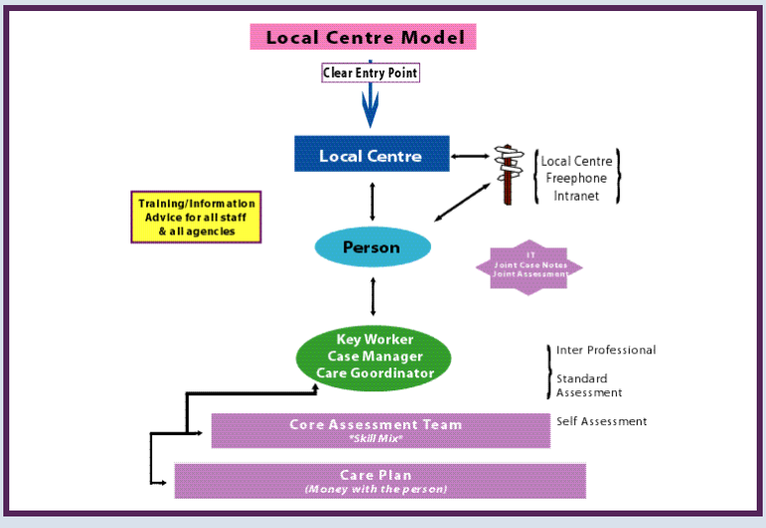
Circle of Need

This model describes the range of needs of individuals, expressed in terms such as spiritual, psychological, housing and including need not identified by the person concerned. The person is in the centre of the network. How these needs are translated into requirements for services are shown outside the circle, including advocacy, health promotion, and information. The system needs to be open and transparent at all stages.



SPAR Model

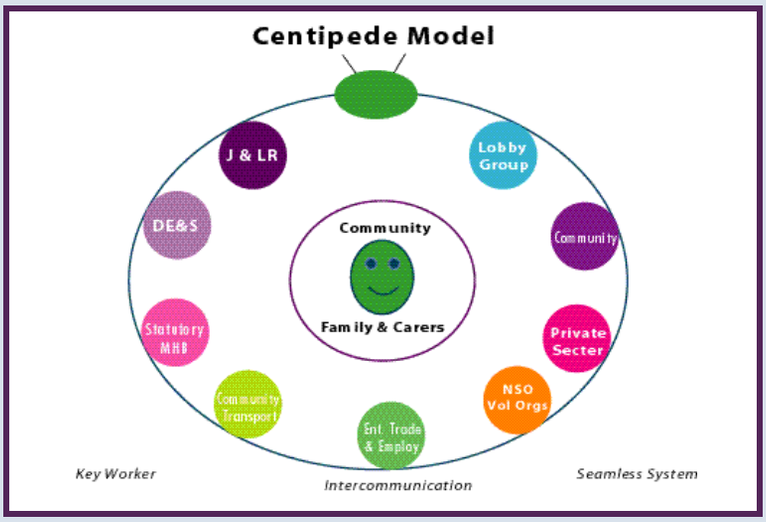
Stage 2 of the above model is translating the needs of an individual into a range of services. The role of a key worker is considered to be crucial for the planning and coordination of support. Services need to be evidence-based supported by research and working to agreed policies and protocols. Services to individuals need to be regularly reviewed and evaluated. The SPAR resource centre (what you need when you need it) may be a "signpost" for individuals onto other services or facilities. The designers of the model stressed the need to "get on with it", acknowledging that much could be done with immediate effect.



Local Centre Model

The Local Centre model stressed the clear entry point into a centre, which provides information, advice and support for all. The centre may be staffed and supported on a multi-agency basis. Communication and information methods would include an MHB freephone plus the intranet & internet. The steps in the process would be assessment and care planning supported by a care co-ordinator, with joint case notes, IT and processes in place.

APPENDIX E - MODELS OF INTEGRATED CARE DEVELOPED IN WOKSHOPS



Centipede Model

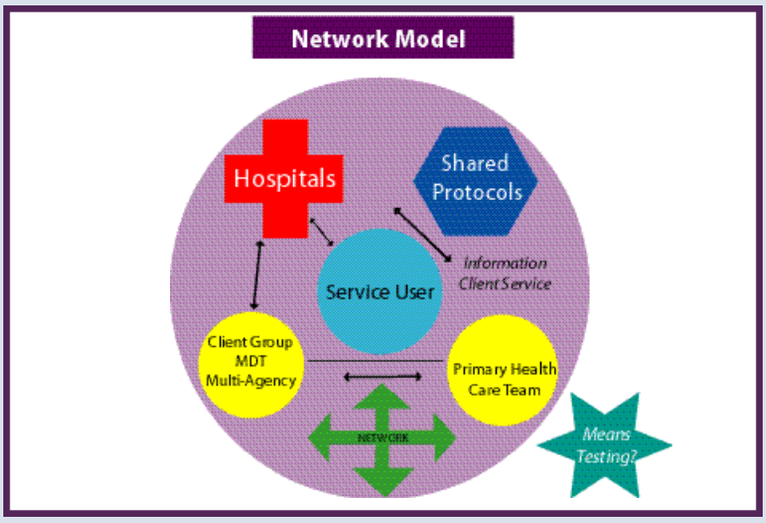
The idea for the centipede came in the description of the key players in the provision of services for people with disabilities. The model illustrates multi-agency involvement including health, employment, training, transport and education. The need for intercommunication in order to deliver a seamless service is shown in the model. Disability is a complex area involving several departments such as health, education, finance, justice, environment etc. The model is a systems map.

Disability System Map
"Currently described as Centipede with all legs going in all directions"

- Need Systems map that integrates care "Holistic Approach"
- Common goal
- Maximise Potential, Quality & Outcome
- Prevention, Education & Research
- Care Pathway
- Inclusive Model - All Stakeholders
- Service 24/7
- Communication, Information, Choices
- Needs Assessment
- Respect Rights Choice & Dignity

Disability Systems Map

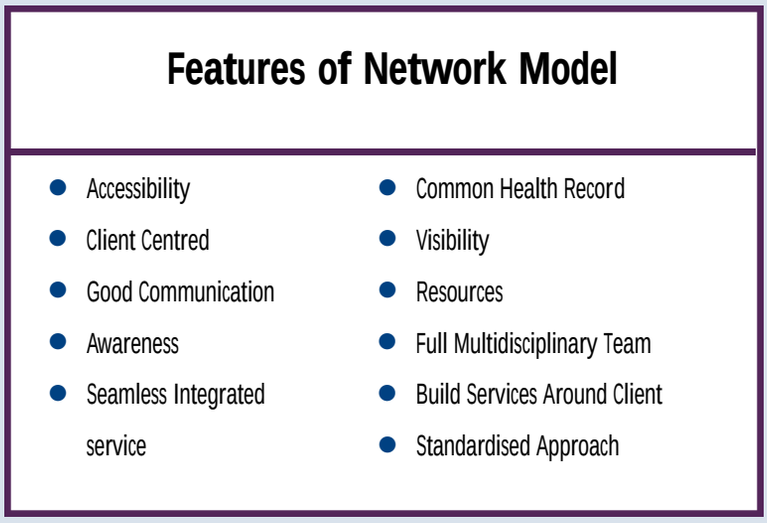
These points are made to show the aspects of the model that need to be in place. For instance, services need to be available 24 hours a day 7 days a week. An Integrated Care Pathway can be developed for many common client needs. Teams working together need to share a common goal, and the needs assessment should be joint and shared. This list of criteria was developed by the disability working group, although the points would be common to all care groups.



Network Model

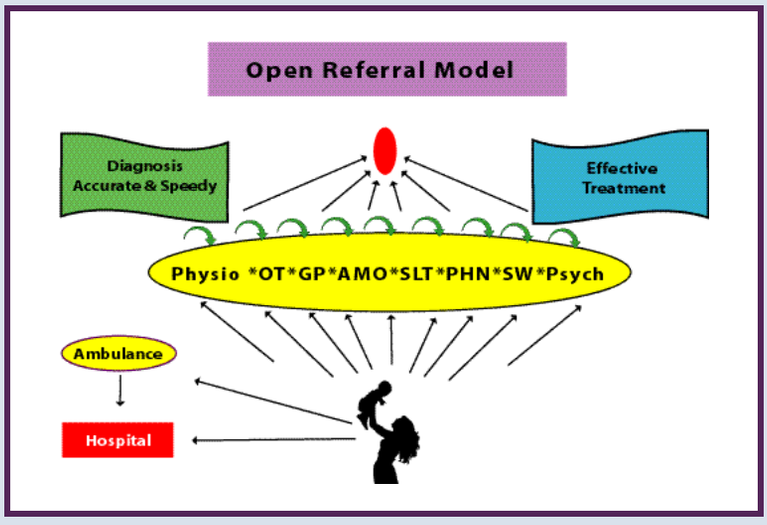
The model shows the service user in the centre of the model, with aspects of services such as primary care and hospital care within the circle. The importance of shared protocols through each stage of health and social care services is shown, and the need for joint assessment, training and shared protocols. The use of information across MDT and multi-agency was stressed by the group. The issue of means testing was raised with a question mark with regard to equity of access and the provision of seamless services.

APPENDIX E - MODELS OF INTEGRATED CARE DEVELOPED IN WOKSHOPS



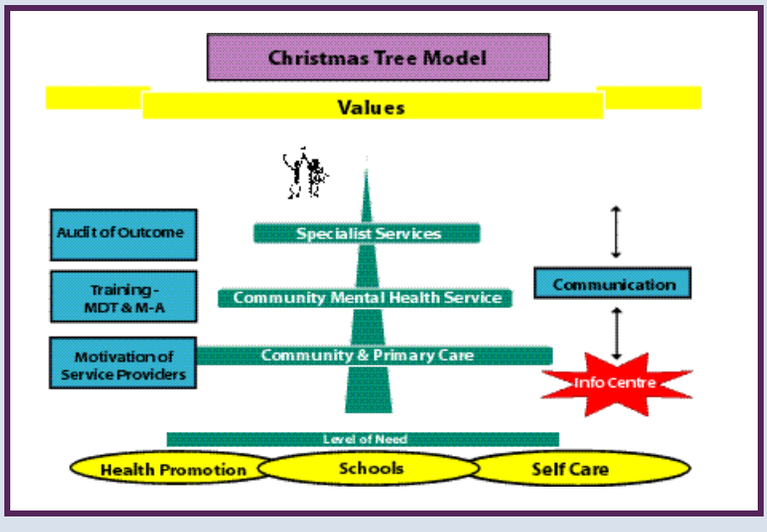
Features of Network Model

The group listed the criteria for the network model above. This includes access, a client centred service and a seamless integrated service. The group stressed the need for a full MDT, acknowledging recruitment difficulties leave some teams being established, short staffed, particularly for specific therapies. The need for a combined health record was listed as a criteria.



Open Referral Model

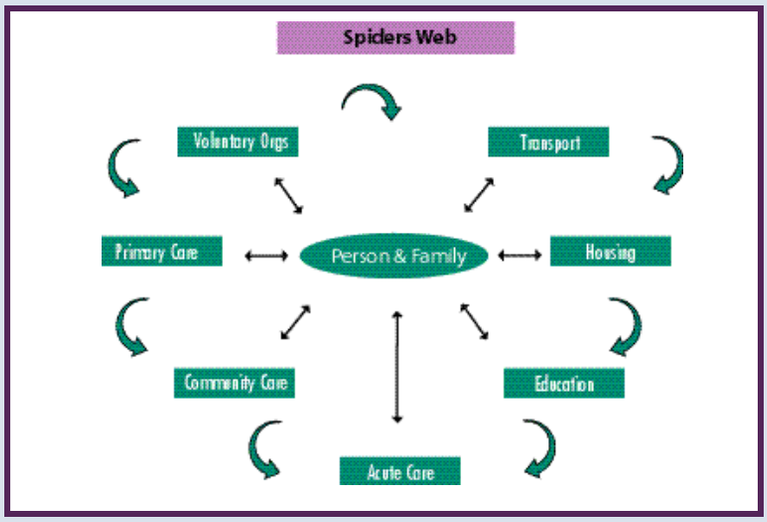
The primary care group who developed this model noted that GPs currently are the gatekeepers to many services, but not all are well placed to refer on appropriately. The group explored the benefits of opening up the referral system in a way where there is a common assessment and ease of cross referral. It was considered that this team approach may help lead to speedier diagnosis and early intervention for a number of clients. It was thought by some members of the team that this extended primary care team would benefit from being co-located, although others believed that "virtual teams" may be more likely. Shared systems were considered essential for the implementation of this model.



Christmas Tree Model

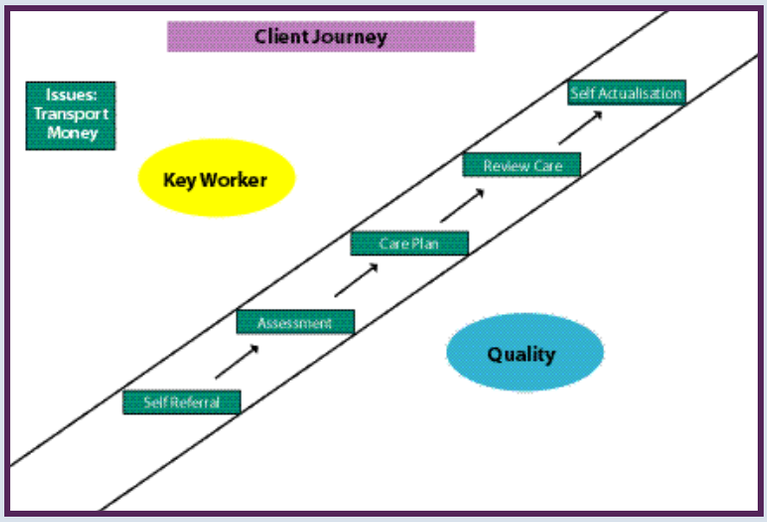
The mental health group who developed this identified the need for integration at the prevention stage and that this could be carried out in schools, through health promotion and self care. Entry into the service would be according to need via an information centre. Specialist services would be available through referral, and that outcomes of care would be audited. A higher number of people would be treated in primary and community care and only those people who need it would be referred onto specialist care.

APPENDIX E - MODELS OF INTEGRATED CARE DEVELOPED IN WOKSHOPS



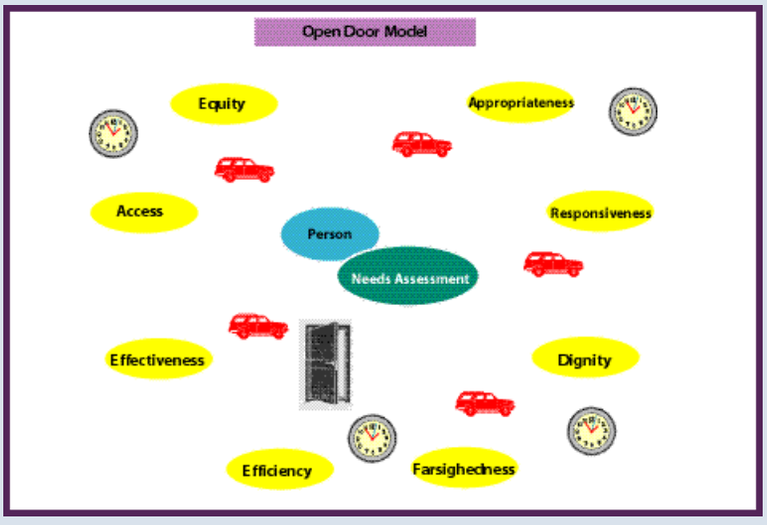
Spiders Web

The children's group who developed this model described the needs of the child and family and the links between these services and organisations. The links between and across each aspect of the service was described as a spider's web.



Client Journey

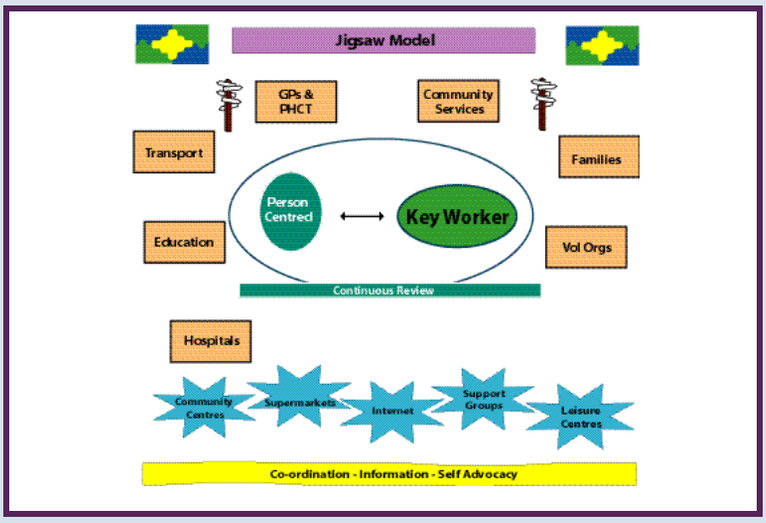
The client journey was a follow on from the spider's web. Once needs were identified the patient/client would go through assessment, care planning, review and would have a goal of self-actualisation. A key worker would guide the process, and the journey would be underpinned by hallmarks of quality. Issues raised by the group included problems of access to services (transport) and the lack of financial resources within some families (benefits) leading members of the group to describe models that took the service to the client.



Open Door Model

This group described the model of integrated care using the 8 values for the MHB. The person is at the centre of the model, and the model is described as an open door, indicating open referral and ease of access to service. The clocks indicate 24/7 care and support that is timely. The cars illustrate the point about the need to help with transport to enable service users to access the services that are provided, as this is currently a significant limitation.

APPENDIX E - MODELS OF INTEGRATED CARE DEVELOPED IN WOKSHOPS



Jigsaw Model

The group showed the client along with their key worker in the centre of the model. The group showed that the service that they received was under continuous review. Information on services to be provided through systems such as through support groups, the internet, via local supermarkets, leisure centres and community centres. The range of services and support is shown signposted around the client. The model is underpinned with information, coordination and self-advocacy.

APPENDIX F - PROFILE OF POPULATION & ACTIVITY

Report June 2003

Population

The total population for the Midland Health Board catchment area is 225,588. The Board covers four Counties; Laois, Offaly, Longford and Westmeath. The population is increasing for all Counties over the past ten years, and in particular in Westmeath.

Population	Number	%
Laois	58732	26%
Offaly	63702	28%
Longford	72027	32%
Westmeath	31127	14%
Total	225588	

Table: Population by County MHB CSO census

Age

The age profile reflects the national profile. One quarter of the population being children aged 14 and under, and just 12% of the population are over 65 years.

Age	%
0 - 14	25%
15 - 64	63%
65 onwards	12%
Total	100%

Table: Age Breakdown (rounded) MHB Annual Report 2001

Beds

The Midland Health Board has 8 beds per 1000 population. Just under one third of the beds are acute.

Beds	Number	%
Acute	513	31%
Long stay	259	16%
Geriatric	582	36%
Psychiatry	281	17%
Total	1635	

Table: Number of Beds by Typology MHB Annual Report 2001

APPENDIX F - PROFILE OF POPULATION & ACTIVITY

Accident and Emergency Attendances

There were 81,000 attendances in 2001 across MHB, with 16% of these were in two GP casualty units.
The A/E Department with the highest attendances is in Westmeath/Longford, reflecting a proportionately high population base.
The attendances numbers include first attendances and follow-ups.

A/E & Cas Attends	Attends 000	%
Portlaoise	17	21%
Longford/Westmeath	28	35%
Tullamore	23	28%
GP Cas	13	16%
Total	81	

Table: Number of Emergency & Unplanned Attendees (Rounded) MHB Annual Report 2001

Out-Patient Attendances

A total of just over 100,000 out-patient attendances are recorded for the year, with the highest number being recorded in Tullamore.

Out-Patients	000	%
Portlaoise	21	20%
Tullamore	36	35%
Mullingar	21	20%
Athlone	4	4%
Longford	8	8%
Other	13	13%
Total	103	

Table: Number of Outpatient Attenders (Rounded) MHB Annual Report 2001

Care Centres for Older People

Care Centers	Beds
Riada House	42
Abbeyleix	50
Tullamore	47
St Brigid's	62
BIRR	70
St Vincent's	170
Edenderry	59
St Mary's	120
St Josephs	171
Loughloe	39
Athlone	116
Total	946

Table: Number of Beds in Care Centres MHB Annual Report 2001

APPENDIX G - OUTCOME OF STAKEHOLDER WORKSHOP 8TH APRIL 2003

Participants in the process identified some key issues that would need to be addressed before progressing with the development of a model for the MHB. Part of the Collective Stakeholder Workshop was devoted to joint discussions on these topics, so that ways of addressing these could be agreed on a multi-agency and multi-disciplinary basis.

An important topic that was not included in the list was the question of how to engage service users in the process of furthering integrated care, and at all stages of planning, managing, delivering and monitoring health and social care. This question was considered to be integral to all topics, as the strong message coming throughout the day was person-centred care. Voluntary agencies and staff were able to start the process of advocating for people that they were supporting.

A total of 10 topics were chosen by the participants in the client-specific and non-statutory agency workshops. Presentations were made on the action required to address these issues in respect of priority, immediate, short term, medium term and in the longer term.

The topics in summary are:

a) Information
b) Teambuilding
c) Referral
d) Streamlining Input
e) Communication
f) Public / Private Health care
g) GPs and Primary Care
h) Managing the Change
i) Access
j) Managing Care

A) INFORMATION

Issue

How to share information whilst safeguarding client confidentiality

Immediate Action

- Common Intake Form and develop a database
- Agree content of form and stratify the Information to manage access to levels
- Key worker with the agreement of the client

Short-Term Action

- Periodic Case Meetings using shared information
- Development of Individual Programme Plans on a MDT basis
- Attend to client groups not currently well catered for (teens, adults, over 6s)

Medium-Term Action

- Develop a Common Database for services and clients
- Develop a Board Information Management protocol – records, contents, levels of maintenance, updating
- Staff education, training, development and support on a shared basis

Long–Term Action
- The client to become the holder of their own file

Priority Action
- Keep client in the loop at all times
- Develop a database
- IT support to care management and associated systems

Summary

The participants working on this topic majored on the development of a database on a macro-level (needs and service mapping) as well as at a micro-level (shared client case notes). The group stressed the importance of the Board making a strong and explicit policy statement on the management of information, and the need to develop ICT solutions to support care management and associated systems. The group also recognised the need to invest in staff training and development in ICT.

B) TEAMBUILDING

Issue

What is the best way to develop teams & clarify accountability when working within an integrated model of care?

Immediate Action
- Compare teams - good & poor
- Good = common goal, person centred, trust, clarity of roles, purpose, holistic approach

Short-Term Action
- Clarification of the aim of the team and of the role of all team members – acknowledge each other's roles.
- Inclusion of consumer on teams & projects

Medium-Term Action
- Education & training
- Need to improve vertical teamwork

Long–Term Action
- Audit & evaluation of team effectiveness

Priority Action
- Include the consumer
- Accountability to client
- What is in the client's best interest?

Summary

The group addressing the topic of teambuilding proposed setting a baseline of teamwork, and the questionnaire results provide a good starting point for this. The group suggested identifying effective team practice, and building on the experience gained from this. The group stressed the fact that the service user was a member of the team, and that accountability within and across the team needed to be clear.

APPENDIX G - OUTCOME OF STAKEHOLDER WORKSHOP 8TH APRIL 2003

C) REFERRAL

Issue

Within integrated care, how do we open up access to services whilst managing referrals and waiting lists?

Immediate Action
- Education & Information
- One stop shop/ Information Centre
- Consultation

Short-Term Action
- Leadership, support & drive from senior management
- Consultation (2-way) & Planning

Medium-Term Action
- Training of key workers
- Management of change – identify resistors
- Identify services currently open – those that would be appropriate & those not

Long–Term Action
- Smaller primary care teams with speedier access (Portarlington project)
- Management of Change & Review
- One Stop Shop/One Start Shop
- Focal Point – appropriate assessment
- Appropriate referral to ICP

Priority Action
- Information – baseline; consultation; public/patients; those providing the service & voluntary groups etc.

Summary

The participants considering the issue of opening up the referral process whilst managing demand started with improving information to the community by way of one-stop shops, one start shops and resource centres. This may lead to more appropriate referral, and opportunities to empower people to self care or find alternative ways of addressing need (not always a medical solution). The group proposed the development of key workers, the introduction of a common assessment process and a more structured and formal approach to managing access to care.

D) STREAMLINING INPUT

Issue

When managing the inclusive nature of MDT & multi-agency service provision, how do we ensure that the client is not overwhelmed?

Immediate Action
- Share Information – within & outside organisation
- F.O.I. update section 16 – update using plain language to clarify what offered
- Role definition

Short-Term Action

- Streamline assessment – common assessment form
- Culture change – professionals to explore interdisciplinary boundaries
- Central point of access – telephone line

Medium-Term Action

- Care Plan Management involving all stakeholders–standards, policies, access.
- Develop key worker system
- appropriate person based on client need; good relationship skills; link for back up & clear accountability.

Long-Term Action

- Evaluate resource needs
- IT systems to talk to each other
- Organisations talking to each other
- Money following the client

Priority Action

- Information sharing within MHB & Population
- Identify Care Pathways

Summary

The group considered the implications of integrated care in respect of the high number of staff who may be involved collectively in an individuals care. Sharing information with the client and between professionals and agencies was given a priority, and also streamlining the process through assessment, a key worker system and care management. Devolving budgets was also a factor in managing care packages.

E) COMMUNICATION

Issue

How do we get the message across to and between staff & clients when providing integrated care?

Immediate Action

- Self-education of professionals
- Clarity to client on use of information
- Talks to local communities (support groups, awareness of rights)
- Staff – MDT minuted meetings

Short-Term Action

- Central information line whilst avoiding duplication
- Contact various media applications (radio, newsletter, video etc)
- Empower community to inform others in the community using groups
- Staff partnership meetings
- Training & Guidelines for staff

Medium-Term Action

- Quality Internal Search Engine
- Information on services online

- Coordination and communication between services
- 1 Stop Shop for information along the model of CAB
- Open & Transparent System for staff - FOI

Long-Term Action

- Tackle issues around confidentiality
- IT systems
- Health Fair
- MDT database

Priority Action

- Share information about project
- Raise awareness

Summary

The group considered the lack of information about services, staff roles, what other teams had to offer, and what is available for patients and carers across the MHB from the wide range of agencies offering health and social care and associated support. Suggestions for improving communication included informal contact to be encouraged between staff and the public, information available on the internet as well as within resource centres and directories. Proposals included a health fair. The group discussed the implications for confidentiality regarding shared information on specific clients, and agreed a protocol was required to be agreed across agencies.

F) PUBLIC/PRIVATE HEALTH CARE

Issue

With a two-tier health service how do we ensure that care is integrated?

Immediate Action

- Mechanisms for communication
- Sharing information – media
- In-Board standardisation – equity
- Public/Private sharing of info

Short-Term Action

- Standardise assessment tools
- Formalise what already exists
- Pilot projects – excellence; one stop shops

Medium-Term Action

- Integrate care planning involving all disciplines
- Integrate service plans
- Pilot projects – care planning

Long-Term Action

- Rights based system – Charter
- Needs assessment MDT
- Patient Centredness
- Equity – 8 Core values

Priority Action
- Communication – PR, media; health promotion
- Accountability & consultation
- Move from medical to social model
- "Empowering the Client" model

Summary

There was concern that a fair, equitable and open system would be compromised by the current two-tier system whereby the services offered by the GP as the gatekeeper attracted a fee from those not on medical cards. The group concentrated on systems that would integrate staff across disciplines at the planning and delivery stage. The group stressed the principle of respecting patient's rights and proposed a patient's charter that incorporated the integrated care model thereby building in choice.

G) GPS AND PRIMARY CARE

Issue

When developing integrated teams with GPs as independent contractors how do we ensure the best service for the client?

Immediate Action
- Networking
- Raise awareness
- Mutual understanding

Short-Term Action
- Communication – workshop & seminars
- Use existing forums – Primary Care Unit, Medical committees
- Pilot schemes & research base

Medium-Term Action
- Create "virtual" teams – access to professionals
- Not necessarily based in practice

Long-Term Action
- Successful integration of teams up and running
- More efficient use of resources
- IT

Priority Action
- Engage GPs when & where appropriate to GPs

Summary

The group considered the role of the GP as integral to the model, and discussed ways of genuinely engaging GPs in the development and implementation of the model. The group considered incentives such as sharing workload, improved use of resources and improving the range of services offered to patients. The group noted the increased collaboration between GPs with the introduction of the out of hours co-op. The group also considered the disincentives for GPs which included the potential loss of income on the way that services were currently reimbursed, and the reduction of autonomy with increased shared working. The adopting and implementation of the primary care strategy was considered to be a key part of developing the integrated care model.

H) MANAGING THE CHANGE

Issue

With the introduction of models of integrated care how do we effect improvements in culture, systems & structures?

Immediate Action
- Empower ourselves & others
- Trust ourselves & others
- Share information

Short-Term Action
- Re-engineer teams (purpose, achieving?)
- Create environment (for individuals & teams) of openness & risk taking
- Review, analyse & recognise change

Medium-Term Action
- Maintain self-esteem / drive for change
- Provide continuous feedback
- Assign goals to groups & individuals

Long-Term Action
- Learn best practice (do not reinvent the wheel)
- Define goals & achievements
- Learn from others such as SE Belfast Trust & NHS & use goals & objectives

Priority Action
- Create opportunities for ourselves
- Take advantage of shared interactions so that we can begin to develop integrated care at an operational level

Summary

The group described the process of managing the change as re-engineering the organisation and the teams working within it. Teams would be reviewed as to their role and purpose, with an aim to increase the level of clarity and knowledge. The group stressed the need to research good practice in integrated care, and to use an evidence base in implementation so that the organisation and staff can build on lessons learnt from elsewhere.

I) ACCESS

Issue

How can we improve access to services? Access to services, location of services & transport? How do we best address access issues whilst ensuring care is integrated?

Immediate Action
- Become more communicative (no jargon) & make communication a priority
- Share information - professionals, statutory and non statutory agencies

Short-Term Action
- Assess the needs of service users (non-stats also assess needs – include in forum)
- 1 central phone number to access services as a precursor to 1 start shop

Medium-Term Action
- Integrated care plans (incl. Service user, family & carer in decision-making & goals)
- Build on models of good access (CRU)
- Look at setting outreach clinics

Long-Term Action
- Out of hours service
- Reorientation of funding – look at direct payments for childcare & transport
- One start shop (access point- service user)
- IT system

Priority Action
- Improve communication at all levels
- Incorporate this into intermediate, short term, medium term & longer term aims
- IT aids reorientation of existing access structures
- Good basis for developing new solutions to access issues

Summary

The group wanted to start with assessing the needs of people who require a service and build up the services and systems of access from that. Systems for sharing information more openly were discussed by the group. The group supported the proposal that a central focal point for information and services for health and social care was provided, such as through a one-stop or one-start shop.

J) MANAGING CARE

Issue

How can we design & implement a care management system that is appropriate for all, consistent, manageable & in keeping with integration?

Immediate Action
- Support a service user forum
- Mentoring system for staff
- Detail what our service is doing & why
- Audit & evaluate current policies

Short-Term Action
- Are current practices in line with best practice
- Identify training needs
- Review existing IT systems
- Undertake population needs assessment

APPENDIX G - OUTCOME OF STAKEHOLDER WORKSHOP 8TH APRIL 2003

Medium-Term Action

- Implement training needs
- Research approach to services
- Further develop electronic patient record system & implement Board wide

Long-Term Action

- Evaluate training & match to ongoing population needs

Priority Action

- Collect data on what we do & how effective it is
- Data is only for planning (no blame)
- Generate awareness of benefits of a managed care system for both staff & clients

Summary

The group were concerned with auditing and evaluating current practices and building on good practice with respect of a care management system. It was recognised that staff would need training and support to implement this more structured way of working. The systems to underpin care management such as effective IT systems were stressed by the group. The group also wanted to raise the awareness of the benefits to the patient, carer and community of implementing a consistently applied care management system across the Health Board.

APPENDIX H - GOVERNMENT BODIES & AGENCIES

Report June 2003

The Government bodies and agencies consulted to date broadly welcomed the process developing at the Midland Health Board. The organisations consulted on the process included various Departments in the Department of Health, HeBE, 4 County Development Boards, Health Research Board, National Disability Authority, Office for Health Management, Mental Health Commission, and GMS. Each organisation stated that the project is in line with the implementation of the National Health Strategy on the person centred approach to delivering services. Each organisation would welcome continued consultation as the process evolves in Midland Health Board.

The focus of the external discussions were to:

- nform them of the project & process to date
- Discuss national and regional initiatives that will impact the project
- Identify key features of integrated working
- Identify known areas of good practice nationally

NATIONAL INITIATIVES

Health Boards Executive Agency

The agency is an enabling body to develop best practice and joint working among all the Health Boards. On integration, they hold a strong belief that the way it will work is: through "National Leadership – Local Ownership" and therefore welcomed the project intentions to date. As the process is an evolving one, it should build in user success stories and a process for validation as it develops. They are familiar with South East Belfast model and viewed it as an excellent model that was built on healthy organic growth.

- **MHB Action:**
  HeBE would welcome a presentation from the MHB CEO on the output from Stage 1. This will provide an excellent platform to gain input from the other Health Board CEOs.

Office for Health Management

The purpose of the Office for health management is to facilitate management and organisation development. It currently is running a number of change management initiatives to implement the national strategy.

- **MHB Action:**
  They have offered to support the change management agenda in the MHB as the process develops. In addition it would welcome a feature on the project in the OHM newsletter to recognise the work of the Midland Health Board staff to date and to promote networking and sharing of interests nationally

Mental Health Commission and Inspector of Mental Health Services

The Mental Health Commission under the Mental Health Act in 2004 will have responsibility for all mental health services. The Mental Health Commission anticipates a revised Inspector of Mental Hospitals function and will be named Inspector of Mental Health Services. The new Inspectorate of Mental Health Services function will advise the Commission on the quality agenda and work with services to examine:

- Quality of services and identification of reasons for variations in service delivery
- Volume and capacity issues
- Code of practice and standards
- Perspectives of service users

APPENDIX H - GOVERNMENT BODIES & AGENCIES

The Commission with its 13 members (comprised of service users and providers) under the Mental Health Act 2001 and has a two-item agenda:

- To establish review tribunals for those detained under temporary orders. This part of the Act will not commence until 2004.
- Quality Agenda: To establish the Inspectorate of Mental Health Services, which will have the broader role of reviewing mental health services as opposed to psychiatric hospitals.

The Commission recognises and endorses the need for more specialised community based psychiatric services. Specialised Community Mental Health teams (Sector Teams) with Community Mental Health Centres should provide services for clients with acute illness in crises, acute illness elderly psychiatry and acute rehabilitation. In addition the development of assertive outreach psychiatric services should foster close links with GPs. The National Strategic Plan for Mental Health will be produced in 18 months, which will endorse the development of Specialised Community Psychiatric Services.

The new Inspectorate function will work in close collaboration with Health Boards on issues of challenge in the provision of Mental Health Services.

- **MHB Action:**
  To assist the workings of the Mental Health Commission and the Inspectorate function, the MHB will have to work closely with the Commission in the delivery of mental health services and incorporate the views and requirements of the Commission and Inspectorate into its information and monitoring strategies. The MHB should be proactive in informing the Commission and Inspectorate of its innovative developments and the views of service providers on issues arising.

Primary Care Task Force

There are currently 10 pilot primary care teams nationally in their infancy under the new Primary Care Strategy. A National Steering Group provides leadership and guidance on the implementation of the new strategy. They meet 3-4 times a year and comprise of 40 multidisciplinary members. Professor Ivan Perry UCC chairs it. Sub groups have been established. Of importance to this project is the subgroup on "Quality and Integration - standards Chaired by Dr Jim Kiely, Chief Medical Officer. It is looking at the interface between primary and secondary care and will be setting national guidelines shortly with guiding principles later in 2003.

The Primary Care Task Force is currently in discussion with HeBE on the development of Primary Care ICT

They will adhere to the following General Principles:

- Common electronic patient record with roll based access to the parts they need bearing in mind confidentiality
- Generate appropriate regional and national information which can be shared
- Facilitate team working
- Provide for remote access.

- **MHB Action:**
  MHB should contact the Primary Care Task Force sub group on Quality and Integration and also closely monitor developments at HeBE on Primary Care ICT

ICT – DOH&C

The National Health Information Strategy is due to be published shortly. Legislation around information will probably be developed. HeBE has recently awarded a contract on IT strategy, which will support and feed into the Information Strategy. They will be looking at standardisation of practice. Little work has been done to date on data protection and the development of the common record. An integration solution is feasible and is the way forward for whole system working. Active national Initiatives to date include:

- IT to support acute hospitals
- Primary Care IT support and investment
- Childcare IT information needs led by Mid West" Childcare Information Strategy - Advanced stage of reporting. Integration and sharing of information is the key.

- **MHB Action:**
  MHB should ensure compatibility with developing projects nationally in ICT on an ongoing basis.

Elderly Services

Nationally, the Interdepartmental Group has put an Integration paper together on the needs of Older People. They hope is that the Primary Care task Force will take the recently published integration paper on elderly on Board. A priority for them is for Health boards to develop a more meaningful relationship with private nursing homes. They currently see the lack of dialogue at the moment means that standards of accommodation slip. With the development of interagency working Health Boards should work closer with Environment. Health Boards should be more proactive on developing Care in the Community, as the elderly clients prefer community-based services. The have obtained limited elderly user views to date and would like to see improvements in the process of consultation with elderly users at a local and national level.

- **MHB Action:**
  The National Council for OAP should be consulted and MHB should keep abreast of developments on the Integration Paper presented by the Interdepartmental Group

Disability

For People with Disabilities and their families- the services delivered and the system to support it should provide information readily to the group. The model should let them easily access meaningful information. Information should be fit for purpose – works with what is already there i.e. the Disability Database. Developed in 1995 it is a living tool, which now has the provision to add other fields e.g. multidisciplinary support services such as speech and language physiotherapy etc. Health Board Directors of Disability should agree information needs with the DOHC, which will identify total services to a person or family and the waiting list. The new disability legislation will place particular emphasis on allocation of resources. It will need clarity from the Health Boards where disability links with other elements of the community service and identify resources disability get from elsewhere.

The National Disability Authority (NDA) current initiatives are as follows:

- ERSI & NDA National Prevalence of Disability. The Pilot in 2004 will provide a definition of disability

- Launch of Disability Standards that are Person Centred. The Department of Justice and Equality reform wants to make the standards mandatory statutory. Health Boards will feel the impact from the NDA on standards implementation in 2004. The standards are pushing for integrated care. They will be audited every 3 years.

- Disability Legislation Consultation Group launched the new Equal Citizens Document in February 2003. They are recommending multi-sectoral needs assessment and coordination of care led by Dept Family and Social Affairs.

- **MHB Action:**
  MHB should consult members of the Consultative Group on Disability Legislation on this project.

Child Protection & Child Welfare

The national goal is to keep the child in the family and family together. To support this a number of springboard projects were launched around the country. There are 2 in MHB.
The Children's Act 2001 has a major impact on community child care services. Phase 1, was legislative. Phase 2 will impact more on services i.e. out of hour's services. Section 2, 3, 11 will be implemented in 2003. Foster care standards have just being published. A priority at the moment is Action 27 – implementation of the National Children's Strategy. On ICT they are putting in place an information system for childcare. Model for child Care MIS was published at the end of 2002. It makes recommendations on the model. The long-term aim is to set standards based on the information from MIS.

- **MHB Action:**
  MHB should monitor compatibility with child Care MIS model

GMS

There are a number of ICT Initiatives in GMS that will support integration as follows:

- The Capitation Download Site – A GP can access start date and exit date. Secure access if GP has certificate. GMS will roll this out to any interested party soon.

- Variety of Claims – STC web based screen – works on user name and password base. You can input claims that are then validated on the spot. Only pay for valid claims. MHB should write into GMS who conduct site visitation (Mid Doc) GMS will roll out similar process for optometrists and dental

- Assistance to Primary Care teams are embryonic

- Central Client Eligibility Index. NEHB will be the first to take it on. Operates on only one health service number per client. Keep key number integrating medical card system. All Health Boards will have within 15 months.

- GMs are developing a web page. It will have starter packs for main starter groups; drug files, annual reports and statistics etc.

- **MHB Action:**
  MHB should contact GMS if they would like to fast track/integrate any of the above ICT projects.

County Development Boards – Regional Initiatives

Common Themes emerged from the 4 County Development Boards. They are as follows:

The Boards provide an excellent vehicle for multi agency partnership working. Vehicles in existence which can be used by the Health Board is the County Community Forum for consultation to connect with the views and issues in each county.

Each County has developed a strategy since their formation in 2000. The subgroups of importance to the Health Board to encourage and enhance integration are the Social Inclusion Measures Group, Health, Education and Security, Housing, Transport and Access.

Health Board representation at County Development Groups is variable based on the decision making powers of the Health Board representative. Health Board representation on Integration should be real. The Health Board seems large and difficult to get decisions made on joint projects to date. For continuity and improved integration, Health Board representation should be real with discretionary decision-making power.

Each County is looking at integration since 2000 and each county is undergoing a population increase. They would like future Health Board information reported by County. This would improve County planning and decision-making

Health Board should feed into Regional Spatial Strategy for all 4 counties. The IT National Tracking System for each County is being developed. The specification was completed in March 2003. The Midland Health Board needs to feed into this. Compatibility is key to good integration.

Legislation states that each agency should consult with the County Development Boards before developing a strategy. They welcomed early consultation on this process. See referenced supporting documents and local issues document.

- **MHB Action:**
  MHB should examine HB representation at County Development Board Groups to ensure that appropriate resources with discretionary decision making powers are deployed. The established Community Forums in the 4 counties should be more widely used to consult with the county population on MHB health issues/matters.

Key Features of Integrated Care

The overall key features identified in the consultation process are summarised below:

- Integration, a strong belief that the way it will work is through "National Leadership and Local Ownership".
- The model should build in user success stories and a process for validation as it develops.
- True multidisciplinary teams should be developed. A need to reduce working upwards through professionals, teams should be working towards professional equals. Move to horizontal rather than vertical working.
- Confidentiality of information should be addressed.
- Fit with other MIS models.
- The services delivered and the system to support it should provide information readily to bodies. The model should let them easily access meaningful information.
- Transparency in funding.

APPENDIX H - GOVERNMENT BODIES & AGENCIES

- Reduce bureaucracy and duplication.
- Twin approach to get professionals located together in the community will improve working.
- Moving continuing care and acute care out of the acute sector into the community.
- Staff should be trained in the value of information collection to improve planning and clinical day-to-day information.
- Person Centred – cases need to be managed on a joint basis by the team. Key worker should vary according to need. Governance issues needs to be addressed.
- Should look at delivery options not always fixed on locations.
- Common electronic patient record with roll based access to the parts they need, bearing in mind confidentiality.
- Generate and share appropriate information regionally and nationally to facilitate team working and provide for remote access.
- One key worker should monitor across the sectors. Needs identified and achieved.

Current Areas of Good Practice

The following projects were identified:

- Best Practice Community Models in Cavan/Monaghan – Mental Health.
- Western Health Board with UCG, looking at models of good practice in Child Care.
- Pilot YAP is making a good impact in Child Care.
- Family support projects are having a good impact in Child Care.
- Recruiting and training foster carers is positive and happening in some Health Boards.
- Mid-West Child Development Services bring in specialist services – Disability.
- North Western have "Choice Programme based on one stop shop - elderly.
- Integrated services process has been geared across social deprivation in Dublin South Inner City - elderly.
- New Zealand model for elderly services.
- Eastern Region Child health and social worker systems.

Conclusion

From the consultation to date it is clear that outside the Health Board, there are a number of excellent vehicles for multi agency partnership working. There are many vehicles in existence and developing to promote integrated care. The time for integration is top of the national and regional health and social agenda. The recommended actions outlined will need to be developed with the relevant external bodies to progress collaboration and integration in the next stage of the process.

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